DOUGLAS H.L. CHIN, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
and Surgery of the Hand and Wrist
80 Grand Avenue, Suite 810
Oakland, CA 94612
(510) 451-6950 (510) 451- 0785 fax

Visit our Web Site
www.bayplasticsurgery.com

Welcome to my practice. My office takes pride in providing you with competent and compassionate care.

We are happy to bill your insurance. In order to do this we need accurate insurance information. Please bring your health plan card and photo identification to your visit. If you cannot provide us with current and correct information, you will be expected to pay in full at the time of service.

Dr. Chin belongs to several PPO & HMO plans and is a participating provider with Medicare. It is your responsibility to know your policy. Please check with your carrier to determine if Dr. Chin is participating in your plan.

Some services may not be covered and you will be financially responsible for those services. All co-payments and deductibles are due at the time of service. **At the Initial Consultation, if you have not satisfied your deductible the Consultation fee of $250.00 is collected at the time of service.** We accept checks, cash, Visa and MasterCard.

If your medical problem is related to a work injury, we must have the Workers Compensation carrier information, claim number, adjuster's name and contact number.

Please arrive 10 minutes prior to your appointment to complete the new patient questionnaire. If you must cancel, a 24 business hour notice is required, you may be charged a cancellation fee if we do not have a 24 business hour notice.

PLEASE DO NOT WEAR SCENTED PRODUCTS.

We appreciate you selecting our office for your medical care and will work hard to serve your needs.

Thank you,

Dr. Douglas Chin

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Referred by _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street & Apt #) _____ (City) _____ (State) _____ (Zip)

Home Phone: _____ **Cell Phone:** _____ **Other Phone** _____

E-mail: _____ **Preferred Contact Method:** ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail

Sex: ☐ Female ☐ Male
Birthdate _____ **SS#** _____ **Marital Status** ☐ Single ☐ Married ☐ Other

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/ African American ☐Pacific Islander/ Native Hawaiian ☐White

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino

Preferred Language: ☐English ☐Spanish ☐Other : _____

Patient's Employer Length of Employment: _____ Date of Injury: _____

Employer Name: _____ Occupation: _____

Work Phone: _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____ (Street & Suite #) _____ (City) _____ (State) _____ (Zip)

Emergency Contact
_____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Primary Health Insurance Company Name: _____
Policy#: _____ Group #: _____ Ins. Phone: _____
Insured: Name _____ DOB: _____ Employer: _____

Secondary Health Insurance Company Name: _____
Policy#: _____ Group # _____ Ins. Phone _____
Insured: Name _____ DOB _____ Employer _____

Preferred Pharmacy: _____

MUST BE SIGNED

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to myself or the named provider for professional services rendered.
Signature: _____ **Date**: _____

RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process this claim.
Signature: _____ **Date**: _____

Medical History

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HEIGHT: _____ **WEIGHT: _____**

PRESENT MEDICATIONS:

Drug Name	Amount (in mg)	Dosage

ALLERGIES(medication name)_____
PREVIOUS OPERATIONS (when & where)_____
_____
PREVIOUS HOSPITALIZATIONS(when & where) _____
_____

PERSONAL HABITS

Have you ever smoked? ☐YES ☐NO packs/day?___ How many years?_____ If you quit, when?_____
Do you drink Alcohol? ☐YES ☐NO If yes, ☐Daily ☐Occasionally
Do you use recreational drugs? ☐YES ☐NO Have you ever use intravenous drugs? ☐YES ☐NO

MEDICAL CONDITIONS

PLEASE INDICATE **YES** OR **NO** TO THE FOLLOWING QUESTIONS

Have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Heart Problems			Thyroid Problems			Stroke		
High Blood Pressure			Kidney Problems			Venereal Disease		
Irregular Pulse			Hepatitis/Jaundice			High Risk for AIDS		
Chest Pain/Angina			Hiatal Hernia/Heartburn			Steroid Treatments		
Respiratory Problems			Ulcers			Alcohol/Drug Addiction		
Asthma			Bleeding Problems			Special Diet		
Fainting			Transfusions			Tuberculosis		
Seizures/Epilepsy			Anemia			Difficulty Urinating		
Numbness/Weakness			Arthritis			History of Child Abuse		
Diabetes			Back Pain			HIV Infection		
Possible Pregnancy?			Neck Stiffness			Alternate Health Treatment		

FAMILY HISTORY

RELATIVE	LIVING	DEAD	CAUSE OF DEATH
Father			
Mother			
Spouse			
Children			

Has any blood relative?

	YES	NO	IF YES, INDICATE WHICH RELATIVE
Had early heart disease?			
Been an alcoholic/drug addict?			
Had Gout?			
Had unusual bleeding tendencies?			
Had death during anesthesia?			

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'Dr. Glen Lau and Dr. Douglas Chin are not partners or otherwise affiliated in the same medical practice. They are independent practitioners who simply share office space, equipment, and staff in their separate practices. They are not responsible for each other's practices or patients.'

_____ _____
Signature of Patient or Legal Representative Date

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FINANCIAL RESPONSIBILITY

Patients must read the following carefully and sign below:

Payment of all charges relating to the evaluation and treatment of medical condition is solely the responsibility of the patient. Insurance payments may offset or entirely cover these costs. However, the patient or the financially responsible agent listed below alone accepts all financial responsibility for medical evaluations and treatments rendered.

For our surgery patients: You will receive two separate bills for your surgery. One bill reflects the professional component (the doctor's charges). The second bill reflects the facility fees (the operating room, nurses, supplies, etc.) and may come from the surgery center or hospital depending on where your surgery takes place. The facility fees are currently billed by Medical Forefronts Financial Services, LLC, our outside billing company. If you have any questions regarding your statements, feel free to call our office and we will be happy to direct you to the appropriate contact.

If your insurance policy has a CAP (maximum amount they will allow for a procedure) and you decide to go ahead with a procedure, you will be responsible for the fee above and beyond the CAP**. It is the patient's responsibility to know their own insurance plan and understand their benefits.**

The undersigned as patient or as agent accepts complete financial responsibility for all charges in full whether or not paid by insurance. Insurance includes Medicare, Private insurance, Disability Payments, Workers Compensation, Legal Settlements and other Health Plans. **Dr. Chin is not a participating provider of Medi-Cal/Medi-Caid, and therefore all charges will be your financial responsibility.**

Name of Patient (please print)_____
Signature of Patient _____**Date**_____

Name of Financially Responsible Party (please print)_____
Signature of Responsible Party _____**Date**_____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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Patient's Name_____

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996(HIPPA) the following is offered for your information and consent. Please be aware that it is office's policy to require your reading and signing this consent from prior to the provision of treatment or any other medical services.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____
_____
_____

_____ _____
Signature of patient or Legal Representative Date

OFFICE USE ONLY
Accepted ☐
Denied ☐

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This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Dr. Douglas Chin , we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Pamela Staten, at (510) 451-6950 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the Dr. Douglas Chin Notice of Privacy Practices. Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____